STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175448	A. BUILDING _____ B. WING _____	C 03/21/2012

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ABERDEEN VILLAGE	17500 WEST 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS 55311.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 3 residents. Based on observation, interview and record review, the facility failed to provide and apply effective safety interventions and adequate supervision for 3 of 3 residents sampled with a history of falls. (#1, #2, #3) Findings included: - Resident #1 admitted from the hospital following a fall with serious injuries in the facility's assisted living unit. Review of resident #1's Physician Order Sheet (POS) dated 1/26/12 revealed diagnoses that included personal history of falls, subarachnoid hemorrhage, difficulty walking, generalized muscle weakness, aftercare follow surgery of the musculoskeletal system, symbolic dysfunction, altered mental status, persistent mental disorder,	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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urinary tract infection, cerebrovascular disease, hypertension, diabetes, type 2, hypothyroidism, osteoporosis, anemia, depressive disorder and hyperlipidemia.

The significant change Minimum Data Set (MDS) 3.0 with an ARD date of 2/8/12 recorded the resident's BIMS score was 4, which indicated severe cognitive impairment. The MDS further recorded the resident required extensive assistance for bed mobility, transfer, locomotion on the unit, dressing, toilet use and personal hygiene, supervision for eating, and did not walk in his/her room or in the corridor.

The falls Care Area Assessment (CAA) dated 2/8/12 recorded the resident was at risk for falls related to multiple falls with a right subdural hematoma [subarachnoid hemorrhage], was very confused and disoriented with impaired balance and used a wheelchair and staff assistance for stability.

The falls care plan dated 2/9/12 directed staff to ensure the resident's bed was at the best height for transfers to help maintain balance, complete a fall risk screen quarterly and as needed, ensure the call light was within reach and remind the resident to use it to call for assistance, encourage activity participation for cognitive stimulation, use non-skid socks or shoes, make sure the resident wore his/her glasses, ensure the environment was hazard and clutter free and had adequate lighting, monitor vital signs, and the physician would review medications for any that increased the resident's fall risk. The care plan also included interventions with dates: 10/2/11, make sure wheelchair brakes were

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locked when the resident was on the toilet, 10/8/11 education of staff on toileting schedule, 10/11/11 do not leave the resident in the bathroom by himself/herself, 10/14/11 keep the door open at night, 10/31/11 bedside commode with bed level suitable for transfers, 11/3/11 re-educate resident to wheel forward and change call light to flat call light pad, 11/16/11 re-educate staff to not leave the resident unattended while sitting on the toilet, and 2/6/12 attach the call light to the resident while sleeping.

The Fall Screening dated 1/2/12 recorded the resident's risk score was 14, (a score equal to or greater than 10 indicated a risk for falls.)

Review of the resident's falls revealed the resident had 10 falls from 10/2/11 through 2/16/12.

The fall dated 10/2/11 at 2:30 P.M. recorded the resident fell in the bathroom when he/she attempted to self-transfer from the toilet to the wheelchair. The new intervention to prevent further falls was staff to lock the wheelchair brakes when the resident was on the toilet.

The fall dated 10/8/11 at 4:15 A.M. recorded the resident fell going in to the bathroom and complained of right thigh pain after the fall. The new fall intervention was education of the staff on the resident's toileting schedule.

The fall dated 10/11/11 at 12:15 A.M. recorded the resident fell in the bathroom and complained of pain in his/her buttocks. The new fall intervention was staff to stay with the resident while in the bathroom at night, and staff educated

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to monitor the resident closely every 30 minutes.

The fall dated 10/14/11 at 3:00 A.M. recorded the resident fell outside the bathroom and complained of lower back pain and stated that he/she hit his/her head on the wall. Staff noted a bump at the back of the resident's head. The new intervention was to keep the bedroom door open to be able to monitor the resident at night. Staff sent the resident to the hospital Emergency Room (ER).

The Resident Transfer Form from the facility to the hospital's ER dated 10/13/11 recorded, "Fall with head injury, [resident complains of] low back pain, has knob to base skull."

The fall dated 10/31/11 at 2:05 A.M. recorded the resident fell when he/she self-transferred from the bed to the wheelchair, and the resident was unsure if he/she hit his/her head. Staff noted 2 abrasions to the resident's back and 1 abrasion to the resident's right knee. The new interventions were to place a bedside commode next to the bed at night and the bed at suitable level [for transfer], and staff to monitor the resident every 30 minutes. (This intervention had already been in place since 10/11/11.)

The fall dated 11/3/11 at 12:00 P.M. recorded the resident fell when he/she attempted to go through his/her doorway backwards in the wheelchair. The new intervention was to change the call light to a flat call pad.

The fall dated 11/16/11 at 10:15 A.M. recorded the resident fell when he/she left the bathroom, and did not know if he/she hit his/her head. The

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new intervention was staff education to not leave the resident unattended while sitting on toilet. (This intervention was already in place since 10/11/11.)

The fall dated 1/2/12 at 3:45 P.M. recorded the resident fell when he/she walked to the bathroom, and staff noted redness to the resident's right upper and lower arm. The new intervention was staff to make sure the flat call light was in reach of the resident. (This is an expected standard of care for all residents.)

The fall dated 2/6/12 at 2:30 A.M. recorded the resident fell when he/she tried to get to the bathroom. Staff noted the resident complained of pain on his/her forehead, and staff noted a lump 4 centimeters (cm.) wide by 2.5 cm. long on the resident's forehead and applied ice, and noted the resident had reddened areas on the right shoulder and shoulder blade. The new intervention was staff to ensure the call light was attached to the resident while sleeping.

Review of the nurses note date 2/8/12 at 2:05 P.M. revealed the resident continued to have bruising to left eye brow area and the bruising moved down past his/her left eye, and the resident stated he/she did not remember the fall.

The fall report dated 2/16/12 at 4:00 A.M. recorded the resident complained of severe pain in his/her left hip and left wrist, and the resident was able to move his/her upper extremities but had difficulty moving the left leg. The resident further stated that he/she fell but did not know when or how. Staff obtained an order for an x-ray of the resident's left hip.

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F 323	Continued From page 5 The x-ray report dated 2/16/12 found the resident had 2 fractured areas on the left hip. The hospital note dated 2/16/12 at 8:22 P.M. recorded the x-ray of the resident's wrist found 2 fractures on the left wrist. The hospital operative report dated 2/18/12 at 9:41 A.M. documented the resident had 2 surgeries, on his/her left hip and left wrist. The resident did not return to the facility. During an interview on 3/14/12 at 7:43 A.M., licensed staff C stated he/she remembered the resident was a fall risk, and staff checked the resident every hour. Other interventions included staff stayed with the resident in the bathroom when the resident was on the toilet and the resident had a fall mat next to his/her bed. Licensed staff C stated the resident was confused, and was only able to use the call light at times, but not regularly. During an interview on 3/14/12 at 2:11 P.M., administrative nursing staff A stated he/she expected licensed staff to implement an immediate intervention after a resident fell and then add the intervention to the resident's care plan and expected staff to read the resident's care plan interventions. Administrative nursing staff A and also stated the facility administrative and licensed staff monitored resident falls and interventions every week during a meeting, and acknowledged the fall interventions for the resident were not effective.	F 323		

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During an interview on 3/16/12 at 8:49 A.M., the resident's family member stated the resident admitted to the hospital on 2/16/12, and hospital staff gave the resident antibiotics for a urinary tract infection and then performed surgery on the resident's left hip and left wrist on 2/18/12. The resident developed pneumonia after surgery and admitted to a hospice facility on 2/20/12, and died 23 hours later on 2/21/12.

The facility provided the policy entitled Falls, dated 12/1/96 which directed residents would be identified for risk of falls and interventions implemented to reduce risk. Resident's high-risk status would be documented on the temporary and/or overall plan of care reflecting appropriate interventions to minimize falls. Nursing staff would implement a system to alert staff to resident's high-risk status.

The facility failed to develop and implement effective interventions and failed to provide adequate supervision for this cognitively impaired, dependent resident with a history of falls.

- Resident #2's Physician Order Sheet (POS) dated 2/27/12 listed diagnoses that included fall, malaise and fatigue, difficulty walking, paralysis agitans, injury to spine and spinal cord birth trauma, muscle weakness, aftercare follow surgery musculoskeletal system, palliative care, urinary tract infection, anemia, pneumonia, post traumatic wound infection, hypertension, hypertrophy of prostate without urinary obstruction, hypoosmolality and/or hyponatremia, contact dermatitis and eczema.

The admission Minimum Data Set (MDS) 3.0 with

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an Assessment Reference Date (ARD) 2/12/12 recorded the resident's Brief Interview for Mental Status (BIMS) score was 9, which indicated the resident had moderate cognitive impairment and he/she required extensive staff assistance for bed mobility, transfers, locomotion on the unit, dressing, toilet use and personal hygiene and required supervision for eating. The MDS recorded the resident had 2 or more falls since the prior assessment.

The admission care plan dated 2/4/12 directed staff, the resident had a history of falling, staff educated the resident on safety measures to reduce fall risk, orient to room and common areas, provide appropriate Activities of Daily Living (ADL) assistance, cue with safety measures, ensure appropriate lighting, and additional interventions included, 2/12/12 re-educate resident to use call light and ask for help with transfers, (non-injury fall at 12:00 P.M.), 2/12/12 keep walker and wheelchair out of reach and sight in his/her bedroom (non-injury fall at 8:00 P.M.) and 2/20/12 keep recliner control out of resident's reach (non-injury fall in his/her room witnessed).

The falls care plan dated 2/15/12 directed staff to perform a fall risk screen quarterly and as needed, ensure the call light was within reach and remind the resident to use it, encourage activity participation for cognitive stimulation, ensure the resident wore his/her glasses, encourage and/or assist to toilet and/or for toileting needs (check and change) if the resident was restless and before and after meals and activities and as needed, ensure the environment was hazard and clutter free and had adequate lighting, the

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physician would review medications for any that increased fall risk, increase assistance during times of illness/fatigue (such as flu), the resident had gait problem ataxia, ambulate with the walker only with staff assistance, the walker could not be in the resident's room, exercise 2 times per day as needed, use a winged mattress on the bed, re-educate the resident to use the call light and ask for assistance with transfers, keep walker and wheelchair out of reach and sight in his/her bed room and additional interventions dated 2/20/12, keep recliner control out of resident's reach and 2/27/12 get resident a floor mat to put next to bed.

Review of the falls screening scores revealed a score of 10 or more indicated the resident was at risk for falls. The fall screening dated 2/7/12 recorded a score of 17. The fall screening dated 2/12/12 recorded a score of 18 and the fall screening dated 2/20/12 recorded a score of 20.

Review of the resident's record and fall reports revealed he/she lived in the facility's assisted living residence from 11/18/12 through 2/2/12, and had 31 falls during that time.

Review of the physician's order dated 2/10/12 directed staff, the resident's "Walker cannot be in [his/her] room."

Review of the resident's fall reports revealed the resident had 4 falls from 2/2/11 through 2/27/12. The fall report dated 2/12/12 at 11:55 A.M. recorded staff found the resident on the floor in front of the [electric lift] recliner. The new intervention to prevent further falls was staff re-educated the resident to use his/her call light

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and ask for help to transfer into the recliner or the wheelchair. (This intervention was already recorded on the resident's admission care plan dated 2/4/12.)

The fall report dated 2/12/12 at 4:00 P.M. recorded staff found the resident on the floor in front of his/her electric lift recliner chair and the resident stated he/she was trying to reach his/her walker. The new fall intervention was staff to keep the resident's walker out of his/her room when resident was in his/her recliner. (The physician previously ordered this intervention on 2/10/12.)

Review of the Physician's Progress Notes dated 2/17/12 recorded the resident had 2 falls over the weekend, and during the physician's interview with licensed and direct care staff learned the resident's "falls had to do with the fact that [his/her] walker was inside in [his/her] room and I had written an order on 2/10/12 that the walker cannot be in [his/her] room. [He/She] did see it and try to get up to it. The second fall was reportedly with [his/her] attempt to get up out of [his/her] recliner."

The fall report dated 2/20/12 recorded the resident moved his/her electric lift recliner chair into the upward position and the resident slid from the chair. The new fall intervention was staff keep the resident's lift chair recliner controller out of the resident's reach.

The fall report dated 2/27/12 at 3:45 A.M. recorded the resident fell on the floor next to his/her bed. The new intervention to prevent further falls was staff to place a mat next to his/her bed.

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The [electric] lift chair safety assessment dated 2/22/12 recorded, "The [direct care staff] use the chair for transfers but the control needs to be out of [the resident's] reach because [he/she] is not safe to use [the] control on [his/her] own."

Observation of the resident 3/8/12 at 3:13 P.M. revealed the resident sat in his/her wheelchair in his/her room. The resident's glasses slid far down his/her nose, his/her left hand tightly grasped the left wheelchair brake lever, his/her right hand had a continuous tremor, and the resident's tongue thrust between words when he/she spoke. The electric lift recliner chair controller lay on the magazine rack next to the recliner in plain sight, and was not out of reach.

Observation of the resident on 3/8/12 at 3:51 P.M. revealed the resident self-propelled his/her wheelchair into the hall.

Observation on 3/8/12 at 4:34 P.M. revealed the resident in his/her wheelchair in the living room common area of the unit and bent over in the wheelchair with his/her feet on the floor and reached down and tried to place the television remote control on the wheelchair foot rest. At 4:37 P.M., staff in the area asked the resident to sit back in the wheelchair and the resident grabbed the staff's hands. At 4:49 P.M., the resident sat in his/her wheelchair, the left foot on the right footrest, and the right foot on the floor, and the resident self-propelled the wheelchair with his/her right hand. The resident continued to hold the remote control in his/her left hand. At 4:52 P.M., the resident had both feet on the floor to the right side of the footrests, and was sharply

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turned in the wheelchair and almost sat sideways in the chair. When staff attempted to place the resident's feet back on the footrests the resident refused and attempted to hit the staff with the remote control.

Observation of the resident's room on 3/8/12 at 5:05 P.M. revealed the electric lift recliner chair controller lay on the magazine rack next to the chair and was not out of reach.

Observation of the resident's room on 3/9/12 at 11:20 A.M. revealed the electric lift recliner chair controller lay on the magazine rack next to the chair and was not out of reach.

Observation of the resident's room on 3/13/12 at 8:47 A.M. revealed the electric lift recliner chair controller lay on the magazine rack next to the chair and was not out of reach.

Observation of the resident on 3/14/12 at 7:01 A.M. revealed the resident slept in bed, with the bed in a low position, and no fall mat in place on the floor next to the bed. A Broda chair (high back wheelchair) was directly next to the bed, placed in the middle of the length of the bed. The electric lift recliner chair controller lay on the magazine rack next to the chair and was not out of reach.

During an interview 3/8/12 at 3:17 P.M. the resident stated he/she had Parkinson's disease, had many falls and he/she did not walk much anymore but thought he/she could walk.

During an interview on 3/8/12 at 4:21 P.M., direct care staff E stated the resident was not too much at risk for falls and had a low bed and the resident

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used the call light.

During an interview on 3/8/12 at 5:15 P.M. licensed staff F stated the resident was a fall risk and staff kept the resident s bed in the low position. Licensed staff F stated the resident fell 1 time from his/her recliner and thought staff should put something in the leather recliner to make it less slippery.

During an interview on 3/9/12 at 4:38 P.M., the resident's family member stated the resident fell often and he/she used to walk but currently was too weak to walk, but the resident did not remember he/she was too weak to walk.

During an interview on 3/9/12 at 9:46 A.M., licensed staff D stated the resident was a fall risk and staff tried to keep the resident in the common area so they could observe him/her unless the resident was in bed. Licensed staff D stated the resident had many falls on the assisted living unit and used the electric lift recliner chair control to stand up and fell, and did not fall out of bed.

During an interview on 3/14/12 at 2:30 P.M., administrative nursing staff A stated he/she expected staff to place the resident's fall mat next to the bed when the resident was sleeping, and the Broda chair should not be placed as an intervention to keep the resident from falling out of bed. Administrative nursing staff A further stated the resident's electric lift recliner chair controller should be out of the resident's reach and sight.

The facility provided the policy entitled Falls, dated 12/1/96 which directed residents would be

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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identified for risk of falls and interventions implemented to reduce risk. Resident's high-risk status would be documented on the temporary and/or overall plan of care reflecting appropriate interventions to minimize falls. Nursing staff would implement a system to alert staff to resident's high-risk status.

The facility failed to implement interventions as planned for this cognitively impaired, dependent resident with a history of falls.

- Resident #3's Physician Order Sheet (POS) dated 3/12 listed diagnoses that included difficulty walking, muscle weakness, muscle spasm, muscle wasting and disuse atrophy, amyotrophic lateral sclerosis, nervous system disorder, late effects of acute poliomyelitis, cauda equina syndrome with neurogenic bladder, irritable bowel syndrome, constipation, open wound of knee, leg and ankle, urinary tract infection, hypoosmolality and/or hyponatremia, aphasia, hypertension, esophageal reflux, anemia, noncompliance with medications and treatments, depressive disorder and history of methicillin resistance staphylococcus aureus.

The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 12/23/11 recorded the resident's Brief Interview for mental Status (BIMS) score was 14, which indicated intact cognition, the resident required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene, required limited assistance for locomotion on the unit, required supervision for locomotion off the unit and eating and had 1 fall since admission or prior assessment, with no injury.

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	175448	A. BUILDING _____ B. WING _____	C 03/21/2012

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F 323	Continued From page 14 The falls Care Area Assessment (CAA) dated 12/23/11 recorded the resident had progressive multisystem post-polio neurodegenerative disorder, required extensive assistance of 2 staff with a Sara lift (standing lift) for transfers to electric wheelchair and to the toilet, wore braces bilaterally on the lower extremities and leaned to the left side, and had depression medication with potential side effects as cause for falls. The fall care plan dated 7/27/10 and updated 12/27/11 directed staff perform a fall risk screen quarterly and as needed, ensure call light is within reach and remind the resident to use it to call for assistance, ensure the bed rails were up as needed to facilitate his/her bed mobility, encourage activity participation for cognitive stimulation, encourage and assist the resident to wear non-skid socks or shoes, remind the resident to lock the wheelchair brakes, ensure the resident had his/her glasses, required total assistance of 2 staff for transfers, encourage and/or assist to toilet and/or for toileting needs (check and change) if the resident was restless and before and after meals/activities and as needed, ensure bed is in the lowest position, ensure environment is hazard and clutter free with adequate lighting, the physician will review medications for any that can increase fall risk, monitor vital signs, offer and encourage snacks and fluids, increase the assistance during times of illness/fatigue (such as flu), if the resident seemed sleepy encourage him/her to nap in bed, educate family and visitors on the assistance the resident needed if leaving the building or if they are going to be assisting the resident with Activities of Daily Living (ADLs), the resident's	F 323		

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mattress had lips around the edge, remind the resident and his/her spouse to call for assistance instead of trying to do it themselves, remind the resident that spouse was not to assist with transfers, the resident agreed to use the call light when he/she needed assistance with transfers and not to ask his/her spouse, and the additional interventions, 11/15/11 make sure the electric wheelchair was charging up when not in use, remind the resident to ask for help by using the call light, and the evaluation note dated 7/27/10 recorded, the resident had a non-injury fall in the last 30 days, will continue to monitor , he/she repeatedly ask his/her spouse to assist him/her or does by himself/herself.

Review of the falls screening scores revealed a score of 10 or more indicated the resident was at risk for falls. The fall screening dated 2/1/11 recorded a score of 11.

Review of the resident's falls reports revealed the resident had 3 falls from 11/15/12 through 1/9/12 which occurred when the resident's spouse transferred the resident. Staff moved the resident's spouse to another unit in January, 2012.

Review of the resident's falls reports revealed the resident had 3 falls from 2/1/12 through 2/12/12. The fall report dated 2/1/12 at 6:00 P.M. recorded staff found the resident on the bathroom floor beside the wheelchair. The new intervention to prevent further falls was educating staff to monitor the resident every 10 minutes while on the toilet.

The fall report dated 2/9/12 at 10:10 A.M.

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recorded staff found the resident on the bathroom floor, and the resident stated he/she hit his/her head. Staff noted an abrasion on the left side of the resident's head and on the resident's left arm just above the elbow area. The new intervention was staff reminded the resident to ask for help and not do things on his/her own. (This intervention was already in place on the 12/27/11 care plan.)

The fall report dated 2/12/12 at 5:45 A.M. recorded staff found the resident on the floor next to the bed. The new intervention was to provide a lower bed.

Observation on 3/8/12 at 9:29 A.M. revealed the resident in bed asleep and did not have a perimeter mattress on the bed.

Observation on 3/8/12 at 11:59 A.M. revealed direct care staff F assisted the resident with personal hygiene care while the resident sat on the toilet. At 12:04 P.M. direct care staff F assisted the resident to stand and used the standing lift to transfer the resident from the toilet to the wheelchair, and did not call other staff to assist during the transfer.

Observation on 3/9/12 at 9:14 A.M., revealed direct care staff F and direct care staff G assisted the resident to transfer from the wheelchair to the toilet. The transfer was completed at 9:18 A.M. and both direct care staff left the resident on the toilet with the standing lift directly in front of him/her on the toilet, and reminded the resident to use the call light for assistance when he/she finished on the toilet, and closed the resident's room door. At 9:24 A.M., observation revealed

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the resident leaned over to the sink to get a glass of water while sitting on the toilet. Observation at 9:31 A.M., 9:40 A.M., 9:43 A.M., 9:50 A.M., and 9:56 A.M. revealed no staff went into the resident's room from 9:18 A.M. until 9:56 A.M. Staff did not check the resident every 10 minutes as planned.

During an interview on 3/8/12 at 12:26 P.M., licensed staff H stated the resident was a fall risk, and the fall interventions included the resident was supposed to ask for help, Sara lift (standing lift) because when the resident tried to transfer himself/herself he/she usually fell, when the resident was in bed, used the mobility bar to sit up, keep the bed at a lower position and level with hips and the wheelchair next to his/her bed and place the flat pad call light on the resident's abdomen when in bed.

During an interview on 3/8/12 at 5:09 P.M., licensed staff F stated the resident was a fall risk and staff did not leave the resident on the toilet unattended, his/her bed was in the lowest position and staff kept an eye on the resident.

During an interview on 3/8/12 at 5:17 P.M., direct care staff E stated the resident was a fall risk, and staff had to watch him/her constantly, had to be with the resident in the bathroom and could not leave him/her with the lift in front of him/her because the resident could still fall off the toilet, the resident had a fall from the bed and staff put the bed in the lowest position.

During an interview on 3/9/12 at 9:24 A.M., the resident stated he/she thought he/she could stand by himself/herself without falling.

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F 323	Continued From page 18 During an interview on 3/9/12 at 9:34 A.M., licensed staff D stated the resident was a fall risk and he/she was physically capable to transfer but not safely, staff transferred the resident and frequently reminded the resident to use the call light but the resident refused, and staff toileted the resident right after meals. Licensed staff D stated the resident was safe alone on the toilet, as long as the standing lift was in front on him/her and staff licked the lift brakes. During an interview on 3/14/12 at 2:42 P.M., administrative nursing staff A acknowledged staff did not follow the fall care plan interventions, and stated it was policy to require 2 staff to assist during a resident transfer with any lift, and the resident required a 2 person lift transfer assist because of the resident's history of falls, and most of the resident's falls occurred in the bathroom or from the toilet. Nursing staff A stated the resident had a couple of beds and staff possibly removed the perimeter mattress. The facility provided the policy entitled Falls, dated 12/1/96 which directed residents would be identified for risk of falls and interventions implemented to reduce risk. Resident's high-risk status would be documented on the temporary and/or overall plan of care reflecting appropriate interventions to minimize falls. Nursing staff would implement a system to alert staff to resident's high-risk status. The facility failed to provide supervision and implement fall interventions for this dependent resident with a history of falls as planned.	F 323		